DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 1 —

2. STATE: WV

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396d(a)(12) and 42 CFR 440.120

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ -675,000
b. FFY 2001 $ -675,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B
Pages 8, 9 and 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Revised reimbursement methodology for certain drugs.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
R. Phillip Shiles, Deputy Commissioner for

13. TYPED NAME:
Elizabeth S. Lawton

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 14, 2000

16. RETURN TO:
Elizabeth S. Lawton, Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/19/00

18. DATE APPROVED: March 23, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V. Campbell

21. TYPED NAME:
CLAUDETTE V. CAMPBELL

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & STATE OPERATIONS

23. REMARKS:

Instructions on Back

4.19 Payment for Medical and Remedial Care and Services

c. Services for Individuals with Speech, Hearing and Language Disorders

An upper limit is established using the relative value for the procedure published in the Health Care Consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will not exceed the provider's customary charge for the service to the general public.

For services provided on and after 11-01-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

Augmentative/Alternative Communication Devices: reimbursement is based on 80% payment of invoice cost for purchase, and 90% payment of invoice cost on repairs.

d. Speech Therapy

An upper limit is established by procedure using a survey of Medicaid coverage conducted by the American Speech, Language, Hearing Association; Medicare upper limits published in the Federal Register 3/21/91; and data compiled from state providers by geographical regions.

12. a. Prescribed Drugs

Reimbursement for prescription drugs shall be the lower of the cost of the drug as defined in paragraphs A and B, plus a reasonable dispensing fee of $3.90, or the usual and customary charges to the general public, including any sale price which may be in effect on the date of the service.

Reimbursement for program drugs is based on the following methodology:

A. Multiple Source Drugs: The upper limit for reimbursement for all multiple source drugs listed in the Federal regulation at 42 CFR 447.332 will be the lower of the established specific upper limit per unit or the provider's usual and customary charges to the general public.

The use of generic drugs is mandated if therapeutically equivalent products are available. A physician may order a brand name drug by writing in his/her

own handwriting, "Brand Medically Necessary" or state such to the pharmacist for an oral prescription order. If the brand name drug is so ordered, the pharmacist may indicate this by using the appropriate "Dispensed as Written (DAW)" code, and reimbursement will be made at the brand drug rate.

All such certified prescriptions must be maintained in the pharmacy files and made available for inspection by the United States Department of Health and Human Services or the State agency.

B. Other Drugs: The upper limit for reimbursement for other drugs will be the lower of the estimated acquisition cost (EAC) or the provider's usual and customary charges to the general public. The EAC of drugs for which no Federal upper limit price has been determined is as follows:

a. the average wholesale price (AWP) less 12%; or

b. the allowable acquisition cost set by the agency for specified drugs or drug categories when the acquisition cost is lower than (a) based on data provided by the drug pricing file contractor or other reliable sources (i.e. direct provider invoices).

The reference price for average wholesale price (AWP) will be as listed in First Databank or other designated National Drug Pricing Publications.

C. Compounded Prescriptions: Payment will be based upon the estimated acquisition cost (EAC) from the current price in effect on the date of service for each ingredient, one of which must be a legend item. A fee of $1.00 will be added to the reasonable dispensing fee for the extra compounding time required by the pharmacist.

D. Compounded prescriptions for parenterally administered drugs: Payment will be based upon the estimated acquisition cost (EAC) of the drug plus a compounding fee determined by the agency to cover the cost of specially prepared admixtures and case management services for drugs requiring parenteral administration.

E. Dispensing fee limitations: Providers of pharmacy services to recipients residing in nursing facilities will be limited to one dispensing fee per drug entity dispensed within the same given month.

F. Assurances: Payment for multiple source drugs will not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee plus an amount established by HCFA that is equal to 150% of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size, as required in 42 CFR 447.332 (a) & (b).

G. Manufacturer Restriction: Reimbursement for prescribed drugs will be limited to those drugs supplied from manufacturers that have signed a national agreement in accordance with Section 1927 of the Social Security Act (The Act), (as amended by Section 4401 of P.L. 101-508).

12. b. Dentures

Payment for dentures is included in item 10.

c. Prosthetic Devices

Payment is based on the upper limit established for the service by Medicare.

d. Eyeglasses

Payment will not exceed an upper limit established considering cost information from national sources; i.e., Optometry Today and Review of Optometry; a survey of practitioners in the State; and the upper limits established by Medicare adjusted to reflect complexity of material.

An upper limit is established for each lens code. The upper limit for frame is wholesale cost up to $40.00 multiplied by a factor 2.5. Payment for low vision aids may not exceed invoice cost plus 30 percent.

Reimbursement may not exceed the provider's customary charge for the service to the general public.

13. d. Rehabilitative Services

Behavioral Health Services

1) Reimbursement to those agencies licensed as behavioral